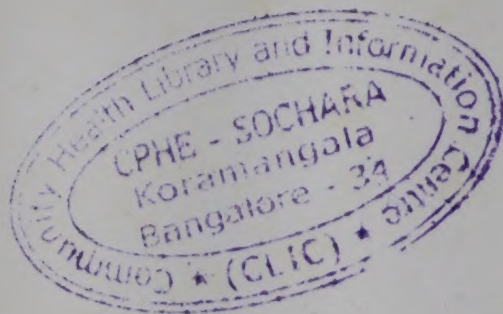


Guidelines for Health Care

in Refugee Camps
of the Somali
Democratic Republic

H-100
N82
Refugee Health Unit,
Somali Ministry of Health



116220

Acc. No. : 3

Class Code : 1.00

REF

**DOCUMENTATION
CENTRE**



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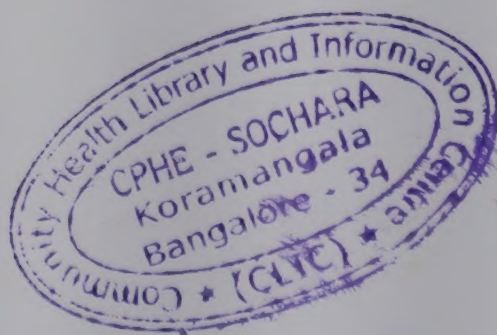
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Compiled by
the Refugee Health Unit,
Somali Ministry of Health

Printed by courtesy of
OXFAM,
274 BANBURY ROAD,
OXFORD OX2 7DZ, UK.
January 1982



PH 100
A82
16220

CONTENTS

INTRODUCTION

PART I. ORGANISATION OF PREVENTIVE HEALTH, HEALTH EDUCATION AND COMMUNITY-BASED SERVICES

PART II. GUIDELINES FOR TREATMENT AND PREVENTION OF MAIN DISEASES AND SYMPTOM COMPLEXES

1. FEVER WITHOUT COUGH
2. FEVER WITH COUGH
3. FEVER AND CHILLS
4. ACHES AND PAINS
5. DIARRHOEA
6. MEASLES
7. EYE INFECTIONS
8. ANAEMIA
9. EAR INFECTIONS
10. SKIN DISEASES
11. TYPHOID FEVER
12. WORMS – INTestinal PARASITES
13. TUBERCULOSIS
14. OBSTETRICS AND GYNAECOLOGY
15. VENEREAL DISEASES

PART III. MOTHER AND CHILD CARE

1. CARE OF THE CHILD – MCH CLINICS (A)
2. CARE OF PREGNANT AND LACTATING WOMEN – MCH CLINICS (B)
3. HOME ACCIDENTS

PART IV. GUIDELINES FOR SUPPLEMENTARY AND INTENSIVE FEEDING PROGRAMMES

- Annex 1. GUIDELINES TO MIXING FOODS FOR SUPPLEMENTARY FEEDING**

PART V GUIDELINES FOR IMMUNISATION

PART VI THE STANDARD DRUG LIST

**APPENDIX 1. DEMOCRATIC REPUBLIC OF SOMALIA,
THE MINISTRY OF HEALTH:
MONTHLY SURVEILLANCE REPORT –
REFUGEE CAMPS**

**APPENDIX 2. SUPPLEMENTARY/INTENSIVE FEEDING
DATA**

INTRODUCTION

This third edition of the "Guidelines" has been produced following discussions and revision of the old guidelines, at the Third Workshop held on August 2nd – 4th, 1981. It is hoped that this edition will be a definitive one, and will not be subjected routinely to revision every six months. The RHU hopes to produce a compact, handbook edition, in both English and Somali.

There are several new sections in these guidelines, covering immunisation, health education, MCH clinics and a revised annex with simplified instructions for the preparation of supplementary food. A new introduction gives some guidance on the organisation of community-based health services, including mechanisms for presenting health education to the refugees. In the curative guidelines, there are extensive revisions of the sections on malaria, tuberculosis, diarrhoea and eye infections.

As stated in the introduction to the second edition of the "Guidelines", these are not meant to comprise a medical text-book. Treatments and control measures have been presented in a simplified format, felt to be the most appropriate in the current refugee camp situation. No lasting service will be done to the refugee community, nor to Somalia as a whole, by the employment by expatriate medical teams of elaborate and costly treatments which cannot be sustained on their departure.

The "Guidelines" are written in a manner suitable for translation into Somali and use by national staff and, after the second phase of training, community health workers. The treatment schedules may appear to be over-dogmatic; however, this has been done purposely, as in the course of time many junior national staff will be transferred from camp to camp or region to region, and it will be an advantage to them to find a standardised treatment and a list of drugs which they have come to know and use effectively.

Finally, the sections on particular diseases have been expanded to include preventive measures and relevant health education topics.

Surveillance Forms

The monthly surveillance report forms remain unchanged, except for the addition of Upper Respiratory Tract Infection under diagnoses. It is realised that some of the information listed is difficult to provide; for example, camp population, births, deaths, etc. However, it is preferable that the forms be incompletely filled in and sent to us promptly each month, than not at all.

Most importantly, the figures for feeding centres should be provided, as these are important in ensuring adequate supplies of supplementary food from Mogadishu, as well as giving us valuable information on the trends of nutrition in the camps.

PART I. ORGANISATION OF PREVENTIVE HEALTH CARE, HEALTH EDUCATION AND COMMUNITY-BASED SERVICES

1. Introduction

The catch-phrases "Do some preventive medicine" or "Do some public health" are often heard, with the response "Very well, but what do I do?". Many of us realise the problem areas in the refugee camps where the application of preventive medicine could achieve good results, but feel that the solutions to the problems are beyond the resources of most medical teams. How can we provide an adequate clean water supply? How can we control insects? How can we build latrines for all the refugees in our camp? Admittedly, some of the desirable measures to improve environmental health conditions are logistically difficult, and in many cases would not be acceptable, nor appropriate, to the refugee situation.

Curative and preventive medicine cannot be separated; there are plenty of opportunities to provide health education at outpatient, TB and MCH clinics. We may very well provide relief and treatment for the sick in the camps, but this effort will be wasted if in the future the refugees leave the camps without any health education to help prevent diseases and to improve their sanitation, personal hygiene, knowledge and nutrition.

The following guidelines have been developed to indicate the importance the Refugee Health Unit attaches to preventive health care activities and to assist camp health staffs in initiating and improving such work. In this section mechanisms are suggested whereby preventive, as well as curative, care can be offered to the entire camp, not only to those fortunate enough to be living close to the fixed-location health services. The following section discusses in detail specific diseases, control measures and points for health education, along with guidelines for treatment.

2. Methods for providing preventive health care, health education and community-based services

It will be the responsibility of the professional expatriate and Somali health staffs, under the direction of the camp medical officer, to establish and supervise the following activities. Not all the activities will be possible in all the camps. However, organisation of section work, as outlined below, is not only feasible in all camps but must be established.

a. Organisation of section work

- (i). Five CHWs, including one TBA, shall be assigned permanently to work in each section or group of 350 to 400 families. They shall have no other daily health duties beyond their section work. Each group of 5 CHWs will have a leader who will be responsible for health work in his/her section. CHWs shall be assigned to work in the section in which they live.

- (ii). A member of the national or expatriate staff will be assigned to supervise the work of the CHWs in the sections.
- (iii). The functions of the CHWs working in the sections will be:
- to teach and encourage personal and environmental hygiene to the persons of the section (health promotion, health education, sanitation).
 - to identify the sick and malnourished in their section by frequent or, if possible, daily visits to each house and to encourage these people to attend the appropriate health facility.
 - to motivate the community to participate actively in health campaigns, such as immunisation and refuse disposal.
 - to find those who are registered for but are not continuing participation (defaulters) in the disease control (TB, leprosy), feeding and health promotion programmes; to know which persons in their section are in the various health programmes and to motivate them to attend regularly; to inform the staffs of the various health programmes of the status of the defaulters from their programmes.
 - to report births and deaths in the section.
 - to treat minor conditions such as wounds and burns (first aid), diarrhoea (ORS/rehydration management), and body aches and pains.
 - to treat ailments under doctor's prescription in their section.
 - to attend deliveries (TBAs only).
- (iv). When a visit to an in-patient is made by a member of the medical staff he/she shall be accompanied by a section CHW. These visits shall be used as an opportunity to provide on-the-job training to the CHWs. The CHW will keep the medical staff informed as to the patient's progress.

b. Health education in the established health services

The medical staff and CHWs should provide health education to those attending the supplementary feeding centres (children, pregnant and lactating women) and clinics (general, TB, MCH, ante-natal) on appropriate topics such as those listed later. This advice should be offered to groups of attendees waiting for services as well as through individual consultations. The importance of preventing disease could be introduced through activities such as requiring children to wash their hands in supplementary feeding centres before they are given their food.

c. Mass campaigns

Immunisation and malaria prophylaxis campaigns have been conducted already through mass mobilisation of the camp populations. Other health activities such as health education and camp clean-up can be most effectively initiated by mass involvement of the refugees. Some camps

have regular meetings in the sections where health topics could be discussed and participation in health activities encouraged. Where regular meetings do not take place, the camp health staff should meet with the camp commander and section leaders in order to plan and implement these activities. For example, to clean garbage from the camp, camp health staff (including CHWs), in conjunction with the camp administration, could conduct section meetings to explain the importance of garbage removal and the details of the coming activities. Then on the day selected for the garbage disposal, camp health staff and section leaders would mobilise the population for participation.

In the long term such mass campaigns will only be effective if they are integrated with the day-to-day health activities of the camp. For example, mass garbage campaigns will indicate to the refugees the importance which the health staff and administration leaders attach to a clean camp, but these campaigns should be followed up by regular health education of individuals or small groups within the sections.

d. Health activities in the regular and Koranic schools

Health personnel should request permission from school leaders to speak to the children on a regular basis on such topics as the importance of washing their hands before eating, not urinating or defecating near household areas, and washing the body to prevent certain diseases. The importance of preventing disease could be stressed through such activities as organising the children to grow a garden in the school area, in conjunction with lectures on the importance of certain foods for maintaining healthy bodies. If certain communal areas in the camp needed cleaning, the children could be organised on a particular day for a clean-up campaign.

e. Women's committees

In some of the camps, a committee of women has been appointed by the camp commander. Although they have not been active in the past, the family life centre programme used them recently to encourage participation of the community in various activities and to obtain needed materials. They could be involved in similar ways in the promotion of health education and other health activities.

PART II GUIDELINES FOR TREATMENT AND PREVENTION OF MAIN DISEASES AND SYMPTOM COMPLEXES

1. Fever without Cough

a. There are many diseases which can cause fever but the commonest is a cold.

b. The symptoms of a cold are:

- a stuffy nose,
- watery eyes and
- a mild sore throat with
- a low fever (take the temperature).

c. Ask about other symptoms:

- fast breathing,
- rattle in the chest,
- stomach pains,
- difficulty in swallowing.

d. Examine the patient.

The following signs observed in a patient are important; if seen, the patient should be referred to a doctor straight away:

- convulsions,
- drowsiness,
- irritability in an infant,
- tender abdomen,
- stiff neck.

low fever
stuffy, runny nose
occasional cough
mild sore throat

Common cold

Treatment:

1. Fluids
2. Reassurance
3. *No medicines needed*

difficulty in swallowing
tender large neck glands
for only a few days
tonsils red and swollen
sometimes with yellow pus

Tonsillitis

Treatment:

1. Fluids
2. Aspirin or paracetamol
3. Penicillin

Adults:

Tab. Penicillin V 250mg
1, 4 times daily x 5 days

OR

Inj. Triple Penicillin
1 single dose vial once
or repeat after 3 days

OR

Inj. Procaine Penicillin
600mg once daily x 5 days

OR

Tab. Cotrimoxazole 2, twice
daily for 5 days

Children:

Tab. Penicillin V 125mg 1,
4 times daily x 5 days

OR

Inj. Triple Penicillin $\frac{1}{2}$
single dose vial once or
repeat after 3 days

OR

Inj. Procaine Penicillin 300mg
once daily x 5 days

OR

Suspn Cotrimoxazole Paediatric
10ml twice daily x 5 days

Infants:

Inj. Benzyl Penicillin
500,000 units twice daily
x 5 days

OR

Inj. Procaine Penicillin 300mg
once daily x 5 days

OR

Suspn. Cotrimoxazole Paediatric
5ml twice daily x 5 days

high fever
no other symptoms

Can be one of many
illnesses

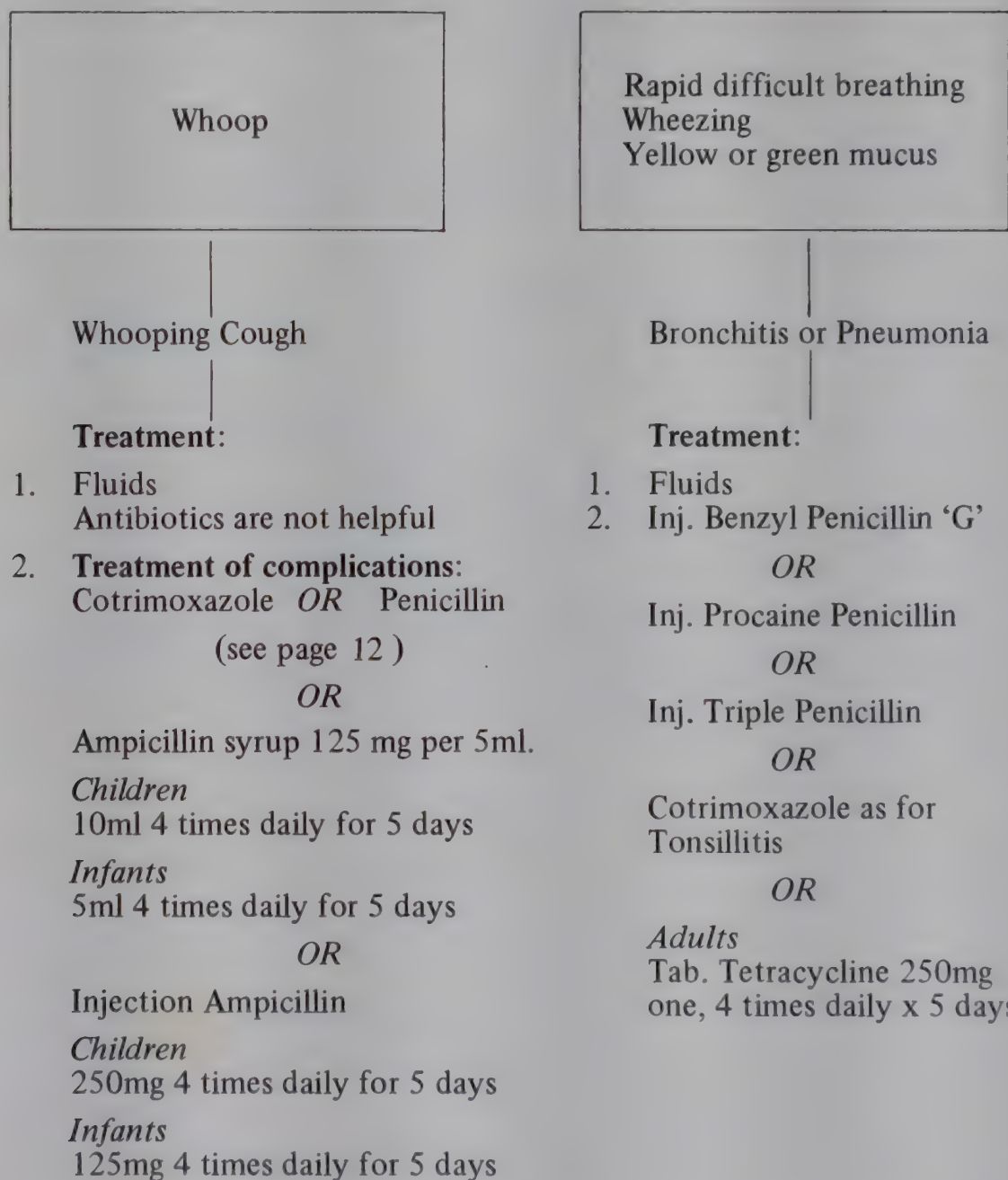
Treatment:

1. Fluids
2. Bring fever down
— take off clothes
— bathe body with
water
3. Aspirin or
paracetamol
4. See in 24 hours
— ask about other
symptoms
— refer to doctor
if fever still
high

2. Fever with Cough

- a. The symptoms of fever with cough can represent many illnesses. Some of these are:
 - Whooping cough,
 - Bronchitis,
 - Pneumonia.
- b. In children it can be difficult to tell the difference between them except what in whooping cough the 'whoop', if heard, gives the answer. And in any case the treatment for bronchitis and pneumonia can be the same.
- c. Diseases of the respiratory tract are spread by coughing or breathing close to other people.
- d. Ask:
 - Is there fever and for how long?
 - (Take the temperature)
 - Is there cough?
 - Is there mucus with cough and if so what colour is it?
- e. Under treatment of whooping cough it is said that antibiotics are not helpful and this is true, but it is also true that pneumonia can happen as a complication and if it does then Cotrimoxazole, Penicillin or Ampicillin should be given.

Fever with Cough



(Note: No Tetracycline for children under 8 years old. Tetracycline should not be given within half an hour of drinking milk.)

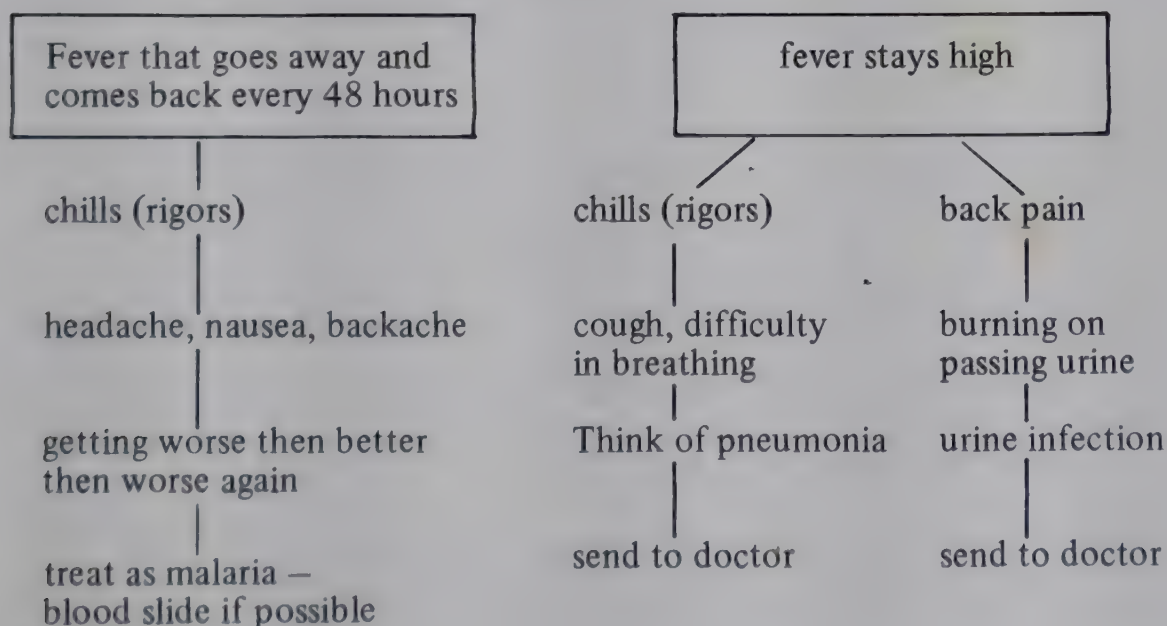
3. Fever with Chills

- a. Many illnesses can cause fever and chills (rigors) including influenza and infections of the urine.
- b. Suspect **MALARIA** if there are repeated shaking chills (rigors), fever that rises fast, headache and sweating followed by a period without fever.
- c. **MALARIA** is caused when a mosquito, which bites someone with the active disease, then goes on to bite another person, carrying to him the organism *Plasmodium Falciparum* (occasionally *P. Vivax*). Over 90% of malaria in Somalia is *Plasm. Falciparum*. There are two seasonal peaks in incidence – between May and July and between October and December.
- d. If you suspect **MALARIA** ask:—
 - Has he been having fever and chills (rigors) for a long time?
 - Does it go away and then come back?
 - How many days between the fevers?
 - Are there headaches?

Malaria should be suspected whenever an unexplained fever occurs during the peak seasons.

- e. Also ask:—
 - Does he have a cough? (He may have pneumonia)
 - Does the urine burn? (He may have infection of the urinary tract)

Fever and Chills



Treatment (MALARIA only)

Chloroquine

Adult: 600mg base at first (4 tablets of 150mg base), then 300mg base after 6 hours, 24 hours and 48 hours from first dose.

Children: (4 - 12 years old)
300mg base at first (2 tablets of 150mg base), then 150mg base (1 tablet) after 6 hours, 24 hours and 48 hours from first dose.

Children under 4 years of age: Use chloroquine syrup (50mg/5mls)
Initial dose is 150mg (15mls) then 75mg (7½mls) 6 hours later, then 7½mls daily for 2 days.

- Note:**
1. Do not use Chloroquine just because someone has fever. Chloroquine is only for MALARIA so do everything you can to make sure the person has MALARIA before you give it. Blood examination is best.
 2. It used to be said that pregnant women should not have Chloroquine, but if a pregnant woman has MALARIA she should have Chloroquine since MALARIA will be likely to do more harm than Chloroquine.

f. VIVAX MALARIA

When confirmed by laboratory, Plasm. Vivax should be treated with Chloroquine as outlined above, followed by Primaquine Phosphate (adults 15mg base daily for *14 days*) 1 tablet = 15mg base.

Children: 5 - 10 years — ¼ tablet daily. Do not give children under 5 years; rather give weekly Chloroquine as a suppressive measure.
10 - 15 years — ½ tablet daily.

g. COMPLICATED MALARIA (FOR PHYSICIANS AND NURSES)

- (i) Cerebral malaria.
Drowsiness, convulsions, localised neurological signs, coma.
- (ii) Renal failure — oliguria, anuria.
- (iii) Algid malaria — diarrhoea, dehydration.
- (iv) Hyperthermia.

Treatment

- (a) Provide adequate fluids, with intravenous infusion if necessary. Beware of giving too much fluid — observe that the patient is passing urine.

- (b) Give parenteral treatment – IM or IV.
IM Chloroquine 200mg 6 or 8 hourly, do not exceed 800mg in 24 hours.
In children, do not exceed 5mg/kg in one dose, repeat once only, after 6 hours.
In cerebral malaria, intravenous quinine gives fast results – start with 10mg/kg in a Dextrose infusion over 3-4 hours. Repeat after 12 hours. Do not exceed 30mg/kg/day in adults, 20mg/kg/day in children under 10.
- (c) Intravenous Hydrocortisone may be of value in cerebral malaria, though this has not been proved.

h. CONTROL OF MALARIA

- (i) Control of mosquitoes – try to drain areas of stagnant water in or near the camp.
Discourage the leaving of uncovered water inside or near houses.
Whenever possible, R.H.U. will organise residual spraying of aqals with DDT, and the placing of larva-eating fish in pools of water.
- (ii) Wherever possible, protection from mosquitoes – nets, clothing.
- (iii) Prophylaxis, especially in vulnerable groups, namely children under 5 years of age and pregnant women, should be instituted in all camps during the peak seasons.

CHLOROQUINE 300mg base weekly in adults.

Children: 6 months - 2 years $\frac{1}{2}$ tablet
2 - 5 years – 1 tablet
5 - 10 years – $1\frac{1}{2}$ tablets
($7\frac{1}{2}$ mls syrup equals $\frac{1}{2}$ tablet)
(children under 6 months – 5mg/kg.)

4. Aches and Pains

- a. Many people, especially old people, often complain of generalised aches and pains.
- b. Carrying heavy loads of wood and water would cause anyone to have aches and pains.
- c. Generally, these are minor problems that go away by themselves.
- d. It is not a problem that needs antibiotics or other medicines.
- e. Treat everyone politely, but do not give everyone medicine.
- f. Examine the patient carefully, this helps to re-assure him.

5. Diarrhoea

- a. Diarrhoea is an important disease which can be very dangerous especially in children by causing loss of water and salt from the body and therefore DEHYDRATION. Any child who has four (4) or more loose stools a day should be given treatment and the treatment of diarrhoea is to prevent DEHYDRATION.
- b. There are many causes of diarrhoea, among them viruses and bacteria. Many kinds of diarrhoea get better without antibiotic treatment and in any case antibiotics are useless in virus infections. Some kinds of diarrhoea produce blood in the stool for which special treatment is advised (see later) BUT ALL KINDS OF DIARRHOEA CAN CAUSE DEHYDRATION.
- c. Diarrhoea comes from dirty food, dirty water and dirty hands.
- d. To find out if someone really has diarrhoea ask these questions:
 - How many loose stools each day?
 - For how many days?
 - Is there blood and mucus in the stool?
 - Is there fever?
 - Is there abdominal pain?

(If someone has four or more loose stools a day he has diarrhoea.)

- (i) **Dehydration.** The most important thing about diarrhoea is that it can cause DEHYDRATION which can cause death, especially of a child already weak because of malnutrition.

Look for these signs of dehydration:

- If a child is crying, are there tears? If no tears, there is DEHYDRATION.
- Are there circles under the eyes? If there are, this is a sign of DEHYDRATION.
- Is the child very thirsty? If yes, DEHYDRATION.
- Are the lips and tongue dry? If yes, DEHYDRATION.
- Gently pinch the skin of the stomach. If it stays wrinkled instead of immediately going flat there is DEHYDRATION (or serious malnutrition).
- Is the Fontanelle depressed? If yes, DEHYDRATION.

- (ii) **Treatment is to prevent DEHYDRATION**, not to cure the infection. All children with diarrhoea should be given treatment. This is good preventive medicine. The infection will go away by itself in a few days.

To prevent DEHYDRATION, the treatment is with Oral Rehydration Salts (ORS).

To prepare ORS, dissolve one package of ORS in one 1 litre of clean water. (If no clean water, boil and cool it before adding ORS.)

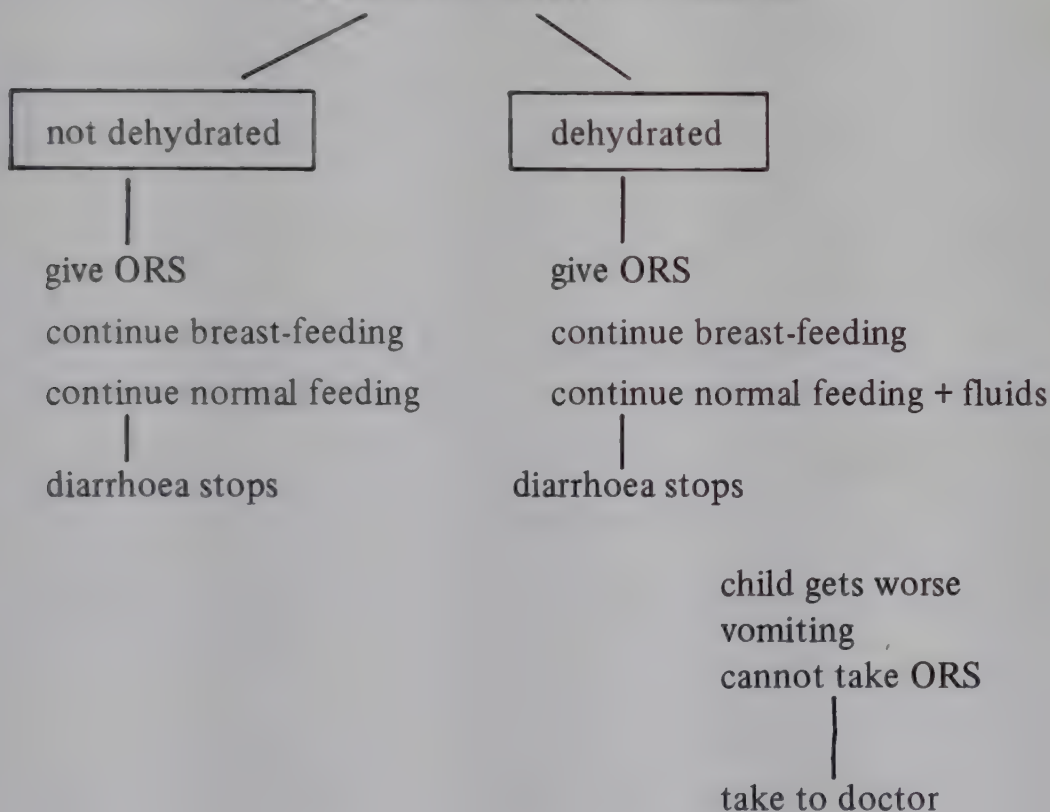
If water can't be boiled, then give any water — this is better than no water.

Normal feeding, or breast feeding, must continue, even when a child has diarrhoea. ORS is usually the only medicine needed for diarrhoea. **DO NOT GIVE ANY OTHER MEDICINE UNLESS THERE IS BLOOD IN THE STOOL.** It can do more harm than good. As well as ORS, the child should continue to receive *other fluids* such as breast milk and water.

If a child is so ill that it cannot take ORS, or if it is getting worse after treatment with ORS, it *must* be taken to a doctor.

Management of Diarrhoea

DIARRHOEA WITHOUT BLOOD



DIARRHOEA WITH BLOOD = DYSENTERY

There are two kinds of dysentery: One is caused by bacteria *and* the other by amoeba.

It is not always easy to tell the difference (except by using a microscope to look at a stool specimen) *but usually*:

BACTERIAL

Sudden onset
Fever
Very frequent, watery stools
Patient very ill

AMOEBIC

Gradual onset
Little or no fever
Foul-smelling stool
Not severely ill

BACTERIAL

Give ORS *or* refer to doctor
(if dehydrated)

Continue breast-feeding
Continue normal feeding

Give Cotrimoxazole as for Tonsillitis

OR

AMPICILLIN

Adults – 250mg. cap.

2 x 4 times daily x 5 days

Children: Syrup 125mg per 5ml

5ml 4 times daily x 5 days

OR

Tetracycline

Adults – 250mg

1 tab. 4 times daily x 5 days

AMOEBIC

Give ORS

Continue breast-feeding
Continue normal feeding

Give Metronidazole (250mg.) for
5 days

Adults – 3 tabs. 3 times daily

Children:

8-10 years: 2 tabs. 3 times daily

4-7 years: 1½ tabs. 3 times daily

2-3 years: 1 tab. 3 times daily

less than 2: ½ tab. 3 times daily

IF VOMITING SEE DOCTOR.

**DO NOT GIVE TETRACYCLINE TO CHILDREN LESS THAN
8 YEARS.**

Amount of ORS

Mix 1 sachet with 1 litre of water then give as follows:

AGE (WEIGHT)	Number of cups of ORS in 24 hours (200ml. cup)	
	(1) IF HYDRATED	(2) IF DEHYDRATED
0 - 6 months (0 - 5kgs)	6 cups	6 cups
6 mths - 2 yrs (6 - 12kgs)	6 cups	8 cups
2 - 5 years (over 12 kgs)	8 cups	12 cups
Older child	10 cups	16 cups

When dehydrated, give **one quarter** of the day's fluid in the first hour.

1 sachet of ORS salts has to be given for every 5 cups of water.

NOTE: GIVING ORS CAN PREVENT DEATH FROM DEHYDRATION!!! THE PATIENT SHOULD STAY AT THE DISPENSARY AS LONG AS POSSIBLE. DRINKING SHOULD BE SUPERVISED!!!

CAREFUL INSTRUCTIONS MUST BE GIVEN TO THE MOTHER ON HOW TO CONTINUE WITH THE TREATMENT. SHE MUST ALSO BE SHOWN HOW TO PREPARE ORS AT HOME.

ORS SALTS MIXED IN TOO LITTLE WATER CAN BE DANGEROUS.

(iii) **Prevention of Dehydration.** Many children die from diarrhoea; it is dangerous for young children and above all for the malnourished.

Preventive measures against diarrhoea:

- Drink boiled water
- Keep water in a closed container
- Keep the house clean
- Keep food away from flies
- Wash hands before preparing food
- Avoid dehydration by giving fluids promptly.

A mother should recognise **dehydration** in her child:

- Dry and loose skin
- Dry mouth
- Sunken eyes
- Little urine
- Weak cry

The baby must go to the clinic if he's dehydrated.

A child with diarrhoea is like a leaking bucket, which has to be constantly filled with water.

The child must drink a lot of fluids — teach mothers how to make a solution with a pinch of salt and a fistful of sugar to a cup of boiled water, to give to their children when ORS is unavailable.

6. Measles

- a. Measles is a very contagious disease caused by a **virus**. It is very common in children and can be very serious and cause death, especially in the malnourished.

Measles can cause severe dehydration and precipitate acute malnutrition — most children lose weight after an episode of measles.

- b. Measles starts with a high fever, watery pink eyes, a runny nose and a cough. You may see white spots in the mouth — called KOPLICK'S SPOTS. On the 3rd or 4th day a rash appears on the face first, and then on the rest of the body. The rash lasts for 4-5 days — it does not feel raised. Mothers usually recognise the illness themselves.

Treatment:

Because measles is caused by a virus, antibiotics do no good. Supportive therapy is the basis of treatment.

Local customs and beliefs about Measles lead to harmful practices such as keeping the child wrapped up, withholding food and fluids, and not washing the child. These should be discouraged, and their harm carefully explained to parents.

Keep the child cool and clean, and give plenty of fluids.

As Keratomalacia has been observed to be precipitated by Measles, we advise a routine dose of Vitamin A 200,000 U. in all cases.

Complications are common after the 4th or 5th day.

- (1) Diarrhoea and dehydration need fluids and ORS.
- (2) Bronchitis, pneumonia and ear infections need appropriate antibiotics.

The child is infective up to the 6th day after the rash appears — after that there is no need to isolate the child.

Prevention:

Measles can be prevented by vaccination and every child between the age of 9 months and 5 years should be vaccinated.

7. Eye Infections

- a. There are many kinds of infections of the eyes. Some get better by themselves. Others can lead to blindness. The most common kind of infection is conjunctivitis, which is usually caused by bacteria or viruses. It is frequently epidemic.
- b. Most conjunctivitis comes from swimming or washing in polluted water, or from close contact with people who have it.
- c. Conjunctivitis commonly affects young children. It does not affect the ability to see.

Trachoma is an important eye infection caused by organisms half-way between virus and bacteria. It is common where people are poor, where there is much dust, little water and many flies.

- d. CONJUNCTIVITIS:
 - a lot of tears coming from the eyes
 - redness of the white part of the eye
 - swelling of the eyelids
 - no loss of sight.

Treatment:

Wash the eyes with clean water – show the mother how to do it.

Eye ointment (tetracycline) four times a day for one week. Put the ointment in both eyes even if only one is infected.

If the infection is severe, with swollen eyelids, it may be gonococcal and needs penicillin.

The infection should be better on treatment after 2 days, certainly within a week. If not, there is probably a foreign body in the eye. Take the patient to the doctor.

e. TRACHOMA

The signs as for conjunctivitis plus:

- (1) follicles (pink-grey swellings in the upper lids)
- (2) pannus (grey edge of cornea)

These are **not** easy signs to see, the lids have to be **everted** – this needs careful practice.

Treatment:

Wash the eyes. 3% Tetracycline eye ointment once a day for 1 month (or 1% three times a day).

Community Health Workers must be taught how to give the ointment.

FACE WASHING PREVENTS TRACHOMA.

- f. Other diseases which can cause eye problems are:
 - Measles (look for the characteristic rash)
 - Leprosy (there will be other symptoms and signs)
 - Vitamin A deficiency.
- g. Sometimes, children who are sick with diarrhoea or pneumonia sleep with their eyes open. This can dry the eyes and lead to blindness. To prevent this, the eyes should be taped closed when the child is asleep.

Prevention: Much eye disease can be treated in children by washing the face with clean water at least twice a day.

- h. Individual patients may also be treated with systemic tetracycline, but this is unsuitable for a mass campaign.
- i. Contacts (e.g. household, classroom) of known cases of trachoma should be treated with tetracycline ointment (3% once daily for 1 week, if no signs of active disease present).

8. Anaemia

- a. A person with anaemia has thin blood.
- b. This happens when blood is lost or destroyed faster than the body can replace it, or if the diet is poor.
- c. Many people with malnutrition will have anaemia.
- d. Anaemia is also found with infections like malaria, hookworm and TB. Look for anaemia in small infants and pregnant mothers.

How to Recognise Anaemia:

Recognition of anaemia is difficult unless it is severe.

Look for paleness of the skin, nails, skin creases in palms of the hands, and insides of the eyelids.

People complain of tiredness and fatigue,

Swelling of the face and hands, shortness of breath and dizziness can indicate severe anaemia.

Treatment:

Treat the cause e.g. hookworm, malaria.

Children: Ferrous sulphate medicine, 5ml three times a day for two months.

Adults: Ferrous sulphate, 1 tablet three times a day for two months.

Prevention of Anaemia:

- If available, it is very important to eat food containing iron, like meat, dark green vegetables (e.g. the leaves of the sweet potato plant), fish and eggs.
- Give supplements of iron to **all high risk groups** – children in feeding centres, pregnant and lactating women.

NB Ferrous sulphate powder is available in large quantities, and is suitable for mixing with milk (not CSM) – it has been shown to be quite acceptable if 100gms is mixed with 100 litres of milk – this provides 300mg ferrous sulphate in a 300cc serving of milk.

9. Ear Infections

- a. Ear infections occur frequently in children. They can cause damage to the ear and result in loss of hearing, so proper treatment is important.
- b. The most important cause of ear infections is bacteria which get into the ear from infections of the sinuses, nose, throat and tonsils.
- c. To recognise ear infections:
 - the patient will complain of pain in the ear.
 - sometimes, pus can be seen coming from the ear (this means the infection is more advanced).
 - there is often fever.

It is best to begin treatment at the stage when there is only pain in the ear: that is to say before pus starts to come from the ear.

Treatment:

Cotrimoxazole as for Tonsillitis (see page 12).

OR

Ampicillin as for Bronchitis and Pneumonia (see page 14).

OR

Penicillin injection or tablets.

d. CHRONIC OTITIS MEDIA

This is a common problem, with a chronic discharge from one or both ears.

The basic management is local treatment of the ears. Tell the mother to bring the child to the clinic once a week. Swab the ear with cotton wool, and **very** gently syringe the ear with warm water.

A nurse must carefully train a CHW in the technique. Teach the mother how to swab the ear daily at home – stress that the ear must be kept dry.

Give an antibiotic, as for acute otitis media, for 10 days if he has one or more of these four things:—

- Discharge for less than a month
- Redness of the drum
- Pain in or near the ear
- Fever

If he has none of these things, antibiotics will probably not help.

Tell the mother not to put any local medicines or foreign objects in the ear, and tell her the child must not go swimming.

- e. **OTITIS EXTERNA** is an inflammation (eczema) of the skin of the outer ear passage which can become secondarily infected with bacteria or a fungus or yeast. The commonest symptom is irritation. The treatment is to use drops of Locorten Vioform three times daily for 14 days.

- f. **FOREIGN BODIES**

These are commonly found in children's ears — beads, peas or often maggots.

Do **not** try to remove them with forceps — this will push them in further and damage the drum.

Syringe his ear, often this removes the object. If not, refer him to a doctor or nurse for help.

10. Skin Diseases

- a. Skin diseases are common and there are many different kinds. Many of them can be prevented by washing thoroughly and often with ordinary soap and water. Many skin diseases come from the ground or from dirty surroundings and so are likely to come back again after treatment.

- b. **SCABIES:**

This disease is caused by a small insect which burrows into the skin leaving small tracks which itch. If the person scratches the skin can also become infected by bacteria. The common places to see Scabies tracks are where the skin ends — between fingers and toes, and at the wrists and elbows for example. Scabies is passed from one person to another when they are in close contact — for example, when they share the same bedding.

Treatment:

Use Benzyl Benzoate liquid. This can be rather hot on the tender skin of a child. For him, add twice as much water as of the Benzyl Benzoate. No need to add water for adults.

Wet a piece of cloth in the Benzyl Benzoate liquid and wipe it all over the body except face and head. Leave the body unwashed until the next day, then wash well with soap and water and repeat the treatment, AND on this second occasion wash or boil the family clothes and bedding.

Usually many members of the family will have Scabies if one has it, so it is best to treat them all.

Itching may continue for some days after treatment. This does not mean that the treatment has failed.

c. **IMPETIGO**

This is common. It is commonest on the face where there will be painful sores with yellow pus and crusts.

Treatment:

Wash the affected area twice a day with soap and water and apply Gentian Violet paint. If it is not better in five days give Penicillin by injection or by mouth as for Tonsillitis.

d. **RINGWORM**

This is a common skin lesion in children; it occurs on the body, and on the scalp, and is caused by a fungus. The lesions are like this:

HEAD
chronic
painless
round
bald
pale

BODY
chronic
painless
round
thickened edges
scales in middle
pale

The treatment is to wash the skin with soap and water, dry and then apply Whitfield's ointment. You may have to treat for several months.

e. **LEPROSY**

Leprosy is a chronic skin condition, which occurs in Somalia; it should be suspected in older children and adults with chronic skin lesions.

Leprosy lesions are always chronic, more than 1cm in diameter, painless, not itchy, have no pus. Sometimes they are pale and anaesthetic (numb). If suspected, a doctor should see the patient. If diagnosed, drugs are available in Mogadishu and Hargeisa. The case should be registered, and the RHU notified; drugs can then be made available.

11. Typhoid Fever

a. Typhoid fever is caused by bacteria.

b. Typhoid fever comes from drinking dirty water, dirty milk, or other foods which contain the bacteria which cause it.

- c. Typhoid fever affects the whole body, and causes fever, headache, sometimes a rash, and either diarrhoea or constipation.
- d. Typhoid is not a common diarrhoeal disease – fever and severe illness are much more usual than diarrhoea.
- e. Blood in the stools does not mean Typhoid Fever – blood in the stools rarely occurs with Typhoid fever, and is a complication, not a part of the usual illness.

Typhoid Fever:

- steadily rising high fever
- headache
- belly pain
- diarrhoea or constipation
- rash
- confusion.

If you suspect Typhoid, you should inform a doctor. Cases where typhoid is strongly suspected should be **reported** to the RHU.

Treatment:

Adults: Tab. or Caps. Chloramphenicol 500mg 1 every four hours for 3 days, then 1 every 6 hours for 7 more days (also available in injections) **OR** Cotrimoxazole 2 tablets twice a day for 10 days.

Children: Susp. Chloramphenicol in a dose of 100mg per kilo of body weight per day divided into 4 doses per day for 10 days **OR** Cotrimoxazole syrup as for Tonsillitis but for 10 days.

12. Worms – Intestinal Parasites

- a. Parasites can be harmful, particularly in malnourished children, because they use some of the nutrients which are intended for the child.
- b. The two most important parasites are roundworms and hookworms.
- c. The best way to diagnose these conditions is by microscopic examination of the faeces.
- d. **ROUNDWORMS (ASCARIS)**
 - (i) Adult worms live in the intestine and are sometimes passed in the stool – they are white and several centimetres long. In children they eat much of the food and so the child may not gain weight.

- (ii) There may be no symptoms of roundworm, sometimes there is belly discomfort and bloating. A child may develop a big, soft abdomen. Roundworms can cause asthma or even blood in the sputum.

Treatment:

One dose of **Mebendazole** (2 tablets) is enough to kill roundworms, but they may not be passed in the stool until several days later. The total dose is 200mg, and is the same for adults and children.

Prevention:

The eggs of roundworms are in soil which is contaminated by faeces so when children play in the dirt the eggs get under their nails and then into their mouths.

To prevent them:

- Keep the nails short and clean.
- Tell children not to defecate in or near the house. Cover the child's faeces with dirt when possible.

e. HOOKWORM (ANCYLOSTOMA)

- (i) This is a small worm which is not visible to the naked eye. It lives in the intestine, and in large numbers causes anaemia and weakness.
- (ii) Although the only sure diagnosis is made by microscope, cases of anaemia which are not obviously due to other conditions (e.g. malnutrition, malaria, T.B.) should be treated for hookworm.

Treatment:

When hookworm is diagnosed give Mebendazole 100mg (one tablet) twice a day for **3 days** to both adults and children.

Prevention:

The eggs are passed in the stool, and the larvae which hatch in the soil can enter another person through his bare feet. From there they pass through the lungs and then to the intestine.

To prevent them:

- All persons should defaecate far from the houses in a separate area from the part of the camp where children play.
- If possible, try to provide sandals for all family members to wear.
- If a child is weak and pale, take him to the clinic to see the doctor.

f. PINWORM or THREADWORM (ENTEROBIUS)

- (i) These are small worms which lay many eggs just outside the anus. This causes itching, mainly at night, the child scratches and so the eggs stick under his nails and are carried to his mouth. This causes repeated infection by the worms.

- (ii) **DIAGNOSIS** can be made by placing a piece of sellotape onto the anal area, then transferring it to a slide. The eggs can be seen under a microscope.

Treatment:

Mebendazole in the same dose as for Hookworm.

Prevention:

- Wash a child's hands and anal area when he wakes up, and after a bowel movement.
- Cut his fingernails very short.
- If he has pinworms, wrap some cloth tightly around his buttocks to keep him from scratching, and take him to the clinic for some medicine. Threadworms are not dangerous, but disturb the child's sleep.

13. Tuberculosis

- a. Tuberculosis is a chronic infectious disease which affects all ages and both sexes.
- b. People with TB of the lungs spread it by coughing, sneezing and spitting.
- c. TB can take a long time to develop — from 1 to 3 months.
- d. A person is more likely to get TB if he lives with a person who has it. Medicine is available to prevent this.
- e. Some common signs of TB are:
 - a cough for longer than 4 weeks
 - a tired feeling
 - weight loss
 - sweating at night and
 - bloody sputum.
- f. TB in children is very difficult to diagnose. Children usually do not cough — but they do lose weight, get tired easily, have pneumonia that doesn't go away. They can also have very big glands in the neck or a painful knee or hip or back which makes them limp.
- g. **What a TB Programme Tries To Do**
 - (i) To identify people with TB, because it is an infectious disease.
 - (ii) The best way to identify people is by examining their sputum.
 - (iii) If there is no laboratory in the camp, do not start treating people for TB unless they have certain signs of symptoms. This is very important.

- (iv) Before treating someone for TB, a register should be made. Because the treatment is very long, their location (section, dabshid) should be written down. You must be able to find the patients if they do not come for treatment.
- (v) Patient education is extremely important, and must be given at the start of treatment. Tell the patient that TB is treatable, that he has to be treated for 1 year and take the tablets every day. Tell him that he can infect his own family if he is not treated. If the patient stops treatment he is likely to relapse.
- (vi) A system of house visits must be established, using the CHW in the patient's section. All defaulters from the TB treatment programme should be contacted by this CHW.

h. When to expect TB

- (i) When an adult complains of a cough for more than 4 weeks, or when there is blood in the sputum. There can also be loss of weight and sweating at night.
- (ii) If a child does not get better after a full treatment with antibiotics for pneumonia.
- (iii) When a malnourished child does not gain weight in a well-supervised Supplementary Feeding Programme.
- (iv) When a child who has recently had measles does not gain weight in SFP.
- (v) When a child with big neck glands does not get better with usual antibiotics.

i. When to start treatment if there is no laboratory

- (i) The diagnosis of TB should be made cautiously, as it commits the patient to a 1 year course of drugs with potential side effects.
- (ii) Only the designated physician or nurse in charge of the TB clinic should start treatment.
- (iii) Community health workers and nurses in other clinics, feeding centres or sections should refer all suspected TB cases to this clinic, which should be held at a regular time and place each week.
- (iv) As well as looking for the following specific signs and symptoms, look at the patient's **general condition**. Does he **look** chronically sick? If uncertain, reserve your decision and observe the patient at weekly intervals for another month. Ask if there is a **family history** of TB.
- (v) If a person has at least 2 of the following, **AND** is still sick after a full treatment with other antibiotics for 14 days:

ADULTS

Cough for 8 weeks with sputum
Weight loss
Night sweats/fever more than
2 weeks
Blood in sputum.

CHILDREN

Weight loss in SFP
Fever/tiredness for more
than 2 weeks
Less activity than usual
Big glands in the neck
Swollen painful knee or hip
which makes him limp or pain
in the back.

j. When to start treatment if there is a laboratory

- (i) When TB bacilli are seen in the sputum.
- (ii) Always collect 2 sputum specimens – one when the patient is seen, the other early in the morning.
- (iii) If TB bacilli are not seen, use the same criteria for when there is no laboratory.

Treatment:

The intensive phase is given for 2 months (3 drugs).

The maintenance phase is continued for another 10 months (2 drugs).

However, if attendance is irregular the intensive phase should be extended.
A total of 50 gms of Streptomycin should be given in the intensive phase.

INTENSIVE PHASE:

Adults: Streptomycin 750mg IM daily
(500mg if over 50 years of age).

TB-1 (THIACETAZONE 150mg + ISONIAZID 300mg)
– 1 tab. every day.

This should be taken after meals, and can be divided into
a twice or three times daily dose.

Note 1. If nausea and vomiting occur, **STOP** TB-1 for 2 - 3 days
then re-start using a low dose of Thiacetazone. Give
after meals.

Do this by giving $\frac{1}{4}$ tab. of TB-1, and 2 tabs. of 100mg
ISONIAZID daily for 7 days.

Increase the dose of TB-1 by $\frac{1}{4}$ tablet every 7 days,
while decreasing the amount of ISONIAZID until you
reach the maximum dose of 1 tablet TB-1 daily.

If vomiting persists, change to ISONIAZID 300mg.
daily **plus** ETHAMBUTOL 800mg daily.

DO NOT START TREATMENT WITH ETHAMBUTOL.

If loss of hearing or ringing in the ears occur, refer to doctor, decrease the dose of STREPTOMYCIN, or stop if necessary.

If burning or numbness in the hands or feet occur, refer to doctor — it may be a side-effect of ISONIAZID—give Vitamin B6 50mg daily.

Children: Children tolerate a smaller dose of THIAcetazone than adults, but need a high dose of ISONIAZID. The following is a recommended schedule. Children need 3 drugs for TB, the same as adults:

STREPTOMYCIN — 15mg/kg/day daily for 2 months
— Plus:

TB-1 —

Neonate:	Thiacetazone should not be given. Isoniazid — 100mg. only.
6 months - 1 year: (5 - 8 Kgs)	Thiacetazone 25mg + Isoniazid 150mg (1/6 tab TB-1 + 1 tab. Isoniazid)
1 - 2 years: (8 - 15 Kgs)	Thiacetazone 37.5mg + Isoniazid 175mg (¼ tab TB-1 + 1 tab. INH)
2 - 8 years: (15 - 30 Kgs)	Thiacetazone 75mg + Isoniazid 200mg (½ tab TB-1 + ½ tab. INH)

If vomiting occurs — as for adults — the dose of Ethambutol is 20mg/kg/day.

MAINTENANCE PHASE:

ADULTS: Omit Streptomycin. Continue TB-1 (or INH and Ethambutol).

CHILDREN: Same.

In the maintenance phase, give the patient a daily supply of drugs. The most important factor in successful TB treatment is that it should be continuous and uninterrupted.

Defaulters must be sought out.

SUPPLEMENTARY FOOD

In the intensive phase, assess the patient's nutritional status:

Is he malnourished?

Does he need extra food?

A diagnosis of TB alone should not be an automatic criterion for supplementary food.

In the maintenance phase, supplementary food could be given as an incentive. This should be wet rations so that tablets can be given at the same time.

k. What to do for Contacts of TB patients

Children less than 5 years old who are living with a TB patient should get INH 10mg/kg every day for 6 months. They should start this treatment one week after getting a BCG vaccination.

Check adult contacts to see if they have symptoms. Use the laboratory when possible to examine their sputum.

IMPORTANT NOTE:

There is **no** advantage in treatment TB as an inpatient – the results are just as good when the treatment is taken regularly at home.

14. Obstetrics and Gynaecology

The greater part of maternity care in refugee camps is well provided by Traditional Birth Attendants (T.B.A.) many of whom, as well as possessing their traditionally acquired skill, will have been taught the special module in the Community Health Worker training scheme. Senior medical and nursing staff are recommended to read the syllabus.

From time to time, however, Senior staff will be asked to assist in cases of difficulty. The special problem in this branch of medical care is that the diagnosis will usually be simple but the means of treatment will not be available in the camp. The following advice therefore emphasises the importance of making use of whatever facilities exist in the nearest district or regional hospital of the Somali National Health Service. It is **strongly** advised that obstetric manoeuvres or operations such as internal version or Caesarian Section, should not be attempted in refugee camps.

ANTENATAL CARE

Ensure that pregnant women receive Supplementary food, iron and folic acid tablets and anti-tetanus immunisation. Support the T.B.A. by advice when it is requested. A serious abnormality such as ante-partum haemorrhage should be sent to hospital.

LABOUR

In the event of a T.B.A. asking advice about a long or abnormal labour it should usually be sufficient for Senior Staff to determine whether the women can spontaneously be delivered vaginally and, if not, assist in arranging her move to hospital. Whether forceps delivery is attempted must be a matter of professional judgement in each individual case.

After delivery it would be correct to assist by giving parenteral Ergometrine to control bleeding or to remove a placenta by Brandt-Andrews manoeuvre. But a truly retained placenta or a third degree laceration of the perineum should be treated in hospital.

GYNAECOLOGY

The commonest gynaecological problem is spontaneous incomplete abortion accompanied by excessive bleeding. This sometimes will require the uterus to be emptied surgically. Whether this procedure is to be done in the camp or whether the patient is to be moved to hospital will be a matter for judgement in each individual case.

15. Venereal Diseases

- a. Venereal diseases (V.D.) are passed from an infected to an uninfected person when they have sexual intercourse. They can be serious both for men and women and for babies which the women may bear.

There are two main kinds of V.D., namely Gonorrhoea and Syphilis.

- b. GONORRHOEA

The symptoms of Gonorrhoea in men are:

- thick yellow pus coming from the penis
- painful and frequent urination.

In women there are often no symptoms for a long time after infection but when present they are:

- clear or pus-like fluid coming from the birth opening without itching or unpleasant smell
- painful urination*
- pain in lower part of belly.

* Distinguish from urinary tract infection

Treatment (Adults only)

Inj. Procaine Penicillin 2.4 million units into each buttock intramuscularly

OR

Tab. Tetracycline 500mg seven (7) tablets at first dose followed by one (1) tablet 4 times daily x 10 days.

- c. SYPHILIS

There are three stages in this disease. The first stage is the appearance of a spot or small ulcer on the penis or vulva which is painless and goes away without treatment in a few days or weeks. The second stage, a few weeks or months later, is a rash on the body which does not itch; also, sometimes ulcers in the mouth. Once again the rash and ulcers will disappear in a few weeks or months without treatment.

The patient does not usually feel ill during these two stages. The third stage does not occur usually for some years and need not be considered here.

Treatment:

The treatment of syphilis is:

Benzathine Penicillin, 2.4 million units IM at 1 visit

OR

Aqueous Procaine Penicillin 600,000 Units IM daily for 8 days.

The former treatment is probably more practical in the camps, and assures that the patient does not further spread the disease.

VERY IMPORTANT

Whenever a diagnosis of V.D. is made it is essential to see that the sexual partner(s) of the patient is informed since it is probable that they also will be infected.

This is best done by giving a note to the patient to give to the partner(s) which may read as follows:

“I have been exposed to a serious disease and I need treatment for Gonorrhoea or Syphilis.”

Date of issue:

Name of Health Centre/camp:

It is helpful to write on the note the number which corresponds with the patient's number in the Health Centre Register.

It is advisable that anyone presenting at a Health Centre with such a note should be treated regardless of symptoms.

PART III. MOTHER AND CHILD CARE

1. Care of the Child – MCH Clinics (A)

It is hoped that, in the near future, all camps shall attempt to commence regular under-5 clinics, otherwise known as MCH Clinics. These could be conducted by CHW's under the supervision of a nurse – TBA's should especially be involved, as their role in **health education** of mothers is vital.

The following components should exist:

- Try to enroll all under-5s, including well children.
- Issue a Road to Health card (these are available from RHU) the mother should keep the card.
- Assess the general health of the child, as well as development.
- Monitor weight monthly.
- Provide deworming treatment, Vitamin A and iron supplements.
- When necessary, refer sick children to the general clinic.
- Conduct **health education** classes.

The following points should be covered in health education:

- a. Recognition of **malnutrition** in the child, and how to obtain supplementary food.
- b. Recognition of **dehydration** in children with diarrhoea, and the treatment with fluids. If ORS is unavailable, the mother can make a solution with a pinch of salt and a fistful of sugar to a cup of boiled water.
- c. What to do when a child has a **fever**. Uncover him, give him a cool bath, give lots of water to drink and observe his other symptoms (chills, diarrhoea, cough, rash, vomiting, fits).
- d. Separate children with rashes, sores, lice, respiratory diseases from other children whenever possible.
- e. Protect children from adults or other children with chronic cough.
- f. Bathe children, change their clothes and wash them often, cut finger-nails often.
- g. Whenever there is a campaign of **immunisation** in the camp, make sure the child gets the vaccines which are relevant.
- h. If any money is available for buying extra food, spend it on food which will build a child's body and protect it from disease (fruit, vegetables, meat).
- i. Some foods are available in or near camps, but are not traditional foods. Give them to children, as they accept new foods more easily (fish, chicken, eggs, beans).

- j. If only a small amount of money is available, buy extra food for the children, not sweets or cigarettes.
- k. Before cooking, wash your hands. Keep all utensils clean and don't leave leftover food on plates. Wash fruits and vegetables before eating them.
- l. Infants need to be fed often – at least 3 or 4 times a day. Infants over the age of 6 months need extra food, **as well as** breast milk. At the age of 12 months they should be eating what the other family members eat, in addition to breast milk.
- m. The children in the family should get most of their food at home; if they go to the supplementary feeding centres – this is to provide **extra** food, to **catch up** on weight they have lost.

2. Care of Pregnant and Lactating Women – MCH Clinics (B)

Ante-natal care of pregnant women ensures their health and the health of their unborn children. An ante-natal clinic should be in existence in all camps, with the aim of seeing all pregnant women regularly, at least during the last trimester.

TBA's should be actively involved in these clinics, as they will usually be attending most births. The following should be performed at the ante-natal clinic:

- a. Weight and B.P. checked.
- b. Urine examination, and haemoglobin if indicated, and the facilities available.
- c. Abdominal examination.
- d. TBA's advised of any anticipated complications.
- e. Check for oedema.
- f. Recommend and arrange for supplementary food. Iron supplements should be given to all women, and chloroquine during malaria season.
- g. If a cold chain is in existence, a course of Tetanus Toxoid (3 doses at monthly intervals) should be given.
- h. Arrange for a post-natal home visit; the TBA should inform the midwife after all deliveries.
- i. **Health Education** should cover the following points:
 - (i) The importance of regular visits to the ante-natal clinic.
 - (ii) **Personal hygiene.**
 - (iii) Extra food should be eaten during pregnancy + lactation. Should include meat, fruit and vegetables when available.
 - (iv) **Rest, when feeling tired.**
 - (v) No medicine unless ordered by a doctor (who must **know** she is pregnant).
 - (vi) Should know what is normal, what is abnormal in pregnancy.

Examples:

- Normal:**
- Feeling sick — eat small frequent meals.
 - Indigestion — sleep with head raised.
 - Feet swelling — rest with feet raised; if fingers and face swell go to the clinic.
 - Low back pain
 - Constipation.

- Abnormal:**
- Bleeding from the birth canal, at any time during the pregnancy — go to bed and send for the midwife.
 - Severe anaemia.
 - High blood pressure (she may have headaches, blurred vision, dizziness or oedema all over the body).

(vii) She should know what is normal after delivery, what is abnormal.

- e.g.:
- bleeding
 - discharge
 - severe weakness or dizziness
 - fever
 - swollen, sore, hot breast.

(viii) She should know what to observe in the new baby:

- Colour
- How the baby feeds
- How the baby breathes
- The cord
- That the baby is passing urine and faeces

(ix) Four important points to remember, to ensure a healthy mother and child:

1. The mother should keep her body clean.
2. The mother should keep her baby clean.
3. The mother should eat well.
4. The mother should feed her baby well.

3. Home Accidents

Home accidents are common in the camps — parents should be aware of them and try to prevent them.

a. BURNS

- Do not let children play near a fire.
- Keep matches out of reach.
- A burn must be kept very clean; wash gently with boiled water and do not cover it.
- If the burn is deep or large, the child must drink a lot of fluids, and be taken to the clinic for treatment.

b. POISONING

- Keep all kerosene or gasoline away from children.
- Never keep poisons in other bottles.
- If he swallows kerosene or gasoline, do **not** make the child vomit; take him to see the doctor immediately. Give him a glass of milk if you have any.

c. **DROWNING**

Wells must be very carefully covered, so that children don't fall into them. Keep the young children away from the river. If a child is drowned, put his head down and try to push the water from his mouth and lungs.

d. **FIRE**

Do not put the fire near the wall of the house, especially when the wind is blowing strong.

e. **CUTS**

Keep cuts clean, with boiled water. If there is pus in the wound after a while, take the child to the clinic.

f. **CAR ACCIDENTS**

Teach the children that cars are very dangerous, and they should not play near the roads, or chase cars.

PART IV. GUIDELINES FOR SUPPLEMENTARY AND INTENSIVE FEEDING PROGRAMMES

1. Introduction

The following guidelines have been revised with the object of standardising and improving the Supplementary and Intensive Feeding Programme in the refugee camps in Somalia. They are flexible and may be changed from time to time by the Ministry of Health's Refugee Health Unit in order to meet changing circumstances.

The guidelines have been developed and evaluated by consensus during technical planning sessions, 3-day seminars, and in the course of field work. This has been achieved with the help of the Somali Ministry of Health, the National Refugee Commission, Centre for Disease Control of ESDHEW, UNHCR, WHO, UNICEF, WFP, Red Crescent Society and League of Red Cross Societies and all other Voluntary Agencies working in the refugee health sector in Somalia.

2. Feeding Programmes: Objectives

a. The objectives of the Supplementary Feeding Programmes (SFPs) in (SFPs) in Somalia are:

- To prevent and in some cases treat malnutrition amongst those particularly "vulnerable" or "at high risk" in the refugee camps, through the provision of additional, appropriate foods.
- To involve the refugee community in the day to day management of the programme.
- To facilitate the coverage and nutritional surveillance both of individuals and of the community.

b. The objective of Intensive Feeding Programmes (IFPs) is to:

- Improve the chances of recovery and thereby reduce mortality among the severely malnourished who could not be rehabilitated by general or supplementary feeding.

3. The Management of SFPs

a. Introduction

The following technical procedures have been designed through a process of compromise between a nutritionally ideal situation and what has been demonstrated in the camps to be feasible given the resources such as food, fuel, equipment and manpower, and factors such as culture and traditional feeding habits.

One major factor in the success or failure of a SFP is the understanding by the whole refugee community that the additional food is a **supplement** and **not** a substitute for the general feeding ration.

b. Criteria for entry into a SFP

Selection for admission to a SFP will depend on the resources available e.g. manpower, equipment, food, fuel, etc. Where very limited resources exist a SFP will have to give highly selective feeding in the following order of priority:

- (i) Infants and young children up to and including 115cm in height (115cm in height is assumed to be synonymous with 5 years of age) who are 71% to 80% of the reference median weight for height using the WHO/NCHS reference tables appended to this section. (See Annex 2.)
- (ii) Children with mild oedema (Kwashiorkor).
- (iii) Women in the last trimester of pregnancy, and for the first year of lactation.
- (iv) Selected TB patients judged medically to be undernourished.
- (v) Medical referrals including children discharged from therapeutic feeding programmes.
- (vi) Undernourished children over 115cm in height (6 - 10 years of age), the elderly and the adults of a poor nutritional status and/or with a complicating disease.

As supplies and other resources improve, the aim should be to enroll all those who fall within the above 6 categories.

c. Criteria for Discharge from a SFP

The following criteria should be used to determine when a person is to be discharged from a SFP:

- (i) Infants and young children attaining 85% of reference weight for height and who are active, free from obvious illness and have gained weight without oedema.
- (ii) The opinion of the Senior Doctor or Nurse will determine the discharge of medical referrals, T.B. cases, older children, the elderly and other special cases. Such patients should be reviewed for discharge monthly or at least two-monthly.

d. Supplementary Feeding Centre Procedures

- (i) All people will be registered and issued with identifiable bracelets or some other non-transferable means of identification on admission. Particular attention must be paid to regular attendance and good coverage of the programme to ensure that those most in need shall benefit.

- (ii) All supplementary food must be supplied as cooked rations. People are required to sit and eat the food "on the spot" using locally purchased equipment, Oxfam Feeding Kits, or other equipment as approved by the Ministry of Health.
- (iii) Supervision and the day-to-day management of the programme should be done by both selected refugees and formally trained personnel.
- (iv) The foods most frequently supplied for use in the SFP are dried skimmed milk (DSM), dried whole milk (DWM), and/or corn-soya milk porridge (CSM), vegetable or butter oil, and/or sugar. Various diet combinations can be found in Annex 1, attached to this section. Dried fruit should be distributed when available.
- (v) The daily SFP ration for each person is **at least** 350 calories and 15gm protein in one or two sittings depending on stomach volume and appetite i.e. for adults and older children one sitting only is usually required, whereas young children may require two sittings. The meal should be held at a regular time each day and should not interfere with meal times at home or other major events in the camp. The serving procedure should be rapid and efficient. Special attention should be paid to the cultural factors that may deter some people from attending, e.g. pregnant women in some camps may be reluctant to be seen eating in public especially where males are also congregating.
- (vi) When making up supplementary foods, river water should always be boiled for 5 minutes. Well, spring and purified water should only be boiled if fuel supplies are adequate.
- (vii) To avoid chaos the maximum capacity for a feeding centre is 400 people after which another feeding centre should be opened.
- (viii) All infants and children enrolled in the SFP should receive on admission Vitamin A. The dosage for infants 6 - 12 months is 100,000 IU and for all others 200,000 IU. All children 2 years of age and older should receive single dose Mebendazole treatment for roundworm (see section on Worms-Intestinal Parasites).
- (ix) The CHWs should be responsible for the follow up at home of those people who have not attended for two consecutive days.
- (x) The S.F. centre is an ideal place to offer preventive health care such as health education and every effort should therefore be made to make constructive use of the time, facilities and personnel.
- (xi) The use of infant feeding bottles is **banned** throughout all refugee camps in Somalia. They are associated with infections and the use of wrong milk formulae, so contributing to infant mortality.

e. Assessment

- (i) Frequent visual assessments of the people in a SFP and of the total refugee camp community is of help in attempting to determine the effect or impact of the SFP.
- (ii) Infants and young children of 115cm. and less in height registered in the SFP should be assessed individually as follows:
 - a frequent visual assessment of each child when eating the supplement “on the spot”.
 - the child should be weighed every four weeks at least. Every two weeks is better.
 - the child should receive a rapid clinical assessment at two-weekly intervals. The information on weight should be recorded in the register and compared with the previous weight. Those children losing weight or not gaining weight should be marked in the register with an asterisk and referred within 24 hours to the senior health personnel for a clinical assessment.
 - enquiries should also be made about the child’s diet at home and his frequency of attendance at the S.F. centre.

f. Surveillance

Although many malnourished children are presented to the SF center, others for various reasons languish in the camps. Only by active searches section by section, and aqal by aqal can the majority of malnourished children be identified and entered into the SF programme. Children less than 3 years of age and 85cm or less in height are at greatest risk of malnutrition. Particular efforts should be made to routinely screen this vulnerable group.

- (i) **Refugees in established camps**
In order to ensure good coverage of the SFP and to identify new people, all children less than 115cms in height should be weighed and measured as soon as possible in a new camp, section by section, and where feasible every 3 months afterwards. New arrivals at an established camp should be assessed nutritionally and clinically within 72 hours of arrival. The anthropometric measurements should be performed by the team of Community Health Workers (CHWs) specifically trained and supervised for this purpose.
- (ii) **New arrivals in “transit camps”**
The emphasis must be on the earliest possible removal to permanent camps using clinical judgement to determine priority.

4. The Management of an Intensive Feeding Programme

a. Criteria for Admission to an IFP are as follows:

- (i) Infants and young children up to and including 115cms in height who are 70% or less of the reference weight for height.

- (ii) Children with oedema (kwashiorkor).
- (iii) Medical referrals, e.g. older children or very rarely adults, of very poor nutritional status and a serious complicating disease.

b. Criteria for discharge from an IFP are as follows:

- The child must:
- a) be at least 80% standard weight for height
 - b) be gaining weight without oedema
 - c) be active
 - d) be free from obvious illness
 - e) have a good appetite.

With the exception of a), the same criteria apply to older children and adults.

c. Intensive Feeding Centre Procedures

- (i) All food used for intensive feeding will be supplied cooked in the form of "on the spot" feeding.
- (ii) The food used is similar to that used in the S.F.P. See Annex 1 for the diet formula for High Energy Milk (HEM).
- (iii) The daily IF ration will take the form of specially formulated food calculated to supply at least – 150 calories per kg. body weight per person per day plus – 3g. protein per kg. body weight per person per day.

Small feeds frequently are required and so at least four, preferably five or six feeds per day should be given.
- (iv) A senior nurse or doctor should closely supervise the care of those patients requiring intensive feeding and the Community Health Workers responsible for the follow-up of those patients who do not attend for two consecutive feeds.
- (v) Medical care is secondary to feeding but everyone should be aware of the possibility of the following medical complications of Marasmus:
 - failure to gain weight
 - dehydration
 - infection(s)
 - hypothermia
 - hypoglycaemia
 - severe anaemia.

d. Individual assessment is done as follows:

- weigh every 7 days to monitor progress and ensure the child is neither losing weight nor failing to gain weight.
 - regular clinical assessment at least every 2-3 days.
- The information gained should be recorded on a register and on individual progress cards.

e. Surveillance

- (i) A regular visual assessment of the community, to include searching individual huts to ensure that those too weak to move are not lying in the huts.
- (ii) Where feasible regular nutritional surveys of a sample of the child population should be undertaken.

Annex 1. Guidelines to Mixing Foods for Supplementary Feeding (Dr. Edward Brink, CDC)

The following are presented to expedite mixing into solution food items used in Supplementary Feeding Programmes.

Equipment:

- Oxfam large cooking pot = 100 litres
- Oxfam measuring jugs = 2 litres
- Oxfam cup = 300cc to ridge
- Other litre container. = 400cc to top

Food supplies:

- DSM sack = 25 kg
- CSM sack = 23kg
- Sugar sack = 45kg
- DWM = 25kg
- Oil litre = 1kg

Nutrient Content per 100gms dry ration:

	calories	protein
— DSM	365	35gms
— CSM	380	20gms
— Sugar	400	0
— Oil	900	0

Mixtures:

Mixtures of food items are presented by volumetric proportions. In addition volumetric and weight quantities are calculated for various numbers of people. Dried supplies should be mixed with oil before adding water where appropriate and water should be added slowly.

I. Dried Skim Milk (DSM) and sugar mixture

The following provides for 400cc portions containing
165 calories plus
15 grams of protein

Basic formula by volumes:

1 part DSM		5 parts DSM
4 parts water	or	20 parts water
$\frac{1}{5}$ parts sugar		1 part sugar

Examples:

	100 servings	225 servings
— DSM	8½ litres (4¼kg)	19 litres (9.5kg)
— Water	34 litres	76 litres
— Sugar	1¾ litres (1¾kg)	4 litres (4kg)
Total fluid volume	40 litres fluid	90 litres fluid (approx.)

II. Dried Skim Milk (DSM), oil and sugar mixture

The following provides for **400cc** portions containing
250 calories and
14 grams of protein

Basic formula by volumes:

1 part DSM	or	5 parts DSM
4 parts water		20 parts water
$\frac{1}{5}$ parts sugar		1 part sugar
$\frac{1}{10}$ part oil		$\frac{1}{2}$ part oil

Examples:

	100 servings	240 servings
— DSM	8 litres (4kg)	20 litres (10kg)
— Water	33 litres	80 litres
— Sugar	1 $\frac{2}{3}$ litres (1 $\frac{2}{3}$ kg)	4 litres (4kg)
— Oil	$\frac{4}{5}$ litres ($\frac{4}{5}$ kg)	2 litres (2kg)
Total fluid volume	40 litres (approx.)	96 litres (approx.)

III. Corn—Soya Milk (CSM) oil and sugar mixture

The following provides **300cc** portions containing
270 calories and
11 grams of protein

Basic formula by volumes:

1 part CSM	or	10 parts CSM
2 parts water		20 parts water
$\frac{1}{10}$ part sugar		1 part sugar
$\frac{1}{10}$ part oil		1 part oil

Examples:

	100 servings	200 servings	315 servings
— CSM	11 litres (5½kg)	22 litres (11kg)	35 litres (17½kg)
— Water	22 litres	44 litres	70 litres
— Sugar	1 litre (kg)	2¼ litres (2½kg)	3½ litres (3½kg)
— Oil	1 litre (1kg)	2¼ litre (2¼kg)	3½ litres (3½kg)
Total fluid volume	30 litres (approx.)	60 litres (approx.)	95 litres (approx.)

IV. High Energy Milk (HEM)

A mixture of DSM, oil and sugar providing 1 calorie per cc of mixture. 100cc of mixture contains 3gms of protein and 100 calories. HEM is used in **Intensive Feeding Programmes** in which 150cc (150 calories) per kilogram of body weight is given each day in divided volumes depending on the child's capacity. A minimum of 4 separate feedings daily is necessary especially for children weighing less than 12.5k.

Basic formula by volumes:

1 part DSM		5 parts DSM
$5\frac{1}{5}$ parts water	or	26 parts water
$\frac{3}{10}$ parts sugar		$1\frac{1}{2}$ parts sugar
$\frac{2}{5}$ parts oil		2 parts oil

Examples:

	50 litres	65 litres	100 litres
– DSM	$7\frac{3}{4}$ litres (4 Kg)	10 litres (5Kg)	15 litres ($7\frac{3}{4}$ Kg)
– Water	41 litres	52 litres	81 litres
– Sugar	$2\frac{1}{4}$ litres ($2\frac{1}{4}$ Kg)	3 litres (3Kg)	$4\frac{3}{4}$ litres ($4\frac{3}{4}$ Kg)
– Oil	3 litres (3Kg)	4 litres (4Kg)	$5\frac{3}{4}$ litres ($5\frac{3}{4}$ Kg)

Quantities of each mixture necessary to provide 350 calories:

Note that only HEM provides 1 calorie per cc. To provide 350 calories per day to a child in SFP the following quantities of specific mixtures are necessary.

I. DSM and sugar mixture	2 full Oxfam cups
II. DSM, sugar and oil mixture	2 Oxfam cups filled to the ridge
III. CSM, sugar and oil	1 full Oxfam cup
IV. HEM	1 full Oxfam cup

PART V. GUIDELINES FOR IMMUNISATION

By the time a child becomes 1 year of age he should have completed a full immunisation course against diphtheria, whooping cough, tetanus, polio, tuberculosis and measles.

1. Vaccines, number of doses, dosage size, route of giving

DPT (diphtheria, pertussis and tetanus), 3 doses, 0.5cc, IM (intramuscular).

OPV (oral polio), 3 doses, 2 drops, PO (into the mouth).

MEASLES, 1 dose, 0.5cc, SQ (injection into fat; subcutaneously).

BCG (tuberculosis), 1 dose, 0.1cc, ID (intradermal, into the skin – left upper deltoid).

A disposable syringe and needle is used for each dose of DPT and of measles. BCG vaccine is given using a 1cc non-disposable special glass syringe and a 1cm non-disposable special needle – the very end tip of the needle is sterilised by a flame between each intradermal shot.

2. Vaccine side effects

Mothers should be told:

- DPT vaccine can cause a fever 12 or more hours after injection for approximately 1 day. Aspirin controls the fever.
- As in any fever, a very occasional child will have a seizure. This child should be taken to the doctor or nurse.
- Measles vaccine on occasion causes a fever and/or a measles-like rash 12-16 days after the injection. A child with this rash cannot infect others and the rash will clear in 3 days.
- BCG vaccine will normally produce a 1-2cm sore or ulcer at the injection site. The sore should be kept clean but not bandaged. As a result of this ulcer a small scar is expected. In up to 10% of children given BCG tender swollen nodes in the arm-pit will occur lasting several days.

3. Vaccine schedule – a suggested schedule

	Age in months			
	3 mths	5 mths	7 mths	9 mths
DPT	X	X	X	
OPV	X	X	X	
MEASLES				X
BCG				X

- a. Two or more vaccines can be given at any one time.
- b. DPT and OPV cannot be given at less than 6 weeks intervals. The interval between doses can be a few to several months and protection against disease achieved.
- c. BCG is best given earlier than 3 months of age and, in fact, can be given at birth. Because BCG produces a temporary ulcer we suggest in the above schedule giving BCG as the last vaccine of the series. Secondly, the scar from BCG can then be used as an indicator that the child has completed all immunisations. In camps where adequate birth registers are maintained and MCH clinics function, the decision to give BCG before 3 months of age can be made.
- d. Completion of all immunisations as per this schedule insures high levels of protection against the diseases at the earliest age possible for the child.
- e. Any child less than 5 years of age should receive the complete series of immunisation.
- f. Any person less than 15 years of age should receive BCG.

4. Vaccine handling

- a. All the vaccines are destroyed by temperatures greater than 8°C. Use cold boxes, vaccine carriers, ice packs.
- b. Measles and OPV must be stored frozen at -20°C. When defrosted and held at 4-8°C both can be used for 30 days. Measles and OPV should not be refrozen.
- c. Measles and BCG are destroyed by sunlight. Use cold box, vaccine carrier, cloth or paper cover.
- d. Measles and BCG vaccines must be reconstituted with a diluent just prior to giving the injection. The diluent must be cold (4-8°C) when added to the dried vaccine. A warm diluent will destroy the vaccine.
- e. Reconstituted BCG is viable for 1 hour at environmental temperature and 3 - 4 hours at 4°C. After these times discard the vaccine.
- f. Only 1 day's expected vaccine requirements should be taken from the regional vaccine store to the immunisation clinic. Use cold boxes and ice packs.
- g. Cold boxes should be opened infrequently. Vaccines expected to be used in a two hour period should be transferred to a vaccine carrier when possible.

- h. Vaccine to be used in the next 10 - 15 minutes can be drawn into syringes and placed on a covered ice pack.
- i. Cleaning of the site for injection with water is sufficient.
- j. OPV droppers should not touch the child's mouth. OPV droppers can be removed, washed with soap and water and re-used.
- k. Any partially used vials of vaccine must be destroyed after each vaccine session.
- l. Unopened vials of vaccine are to be returned to cold boxes, and if possible, the cold boxes returned to the regional vaccine store where the vaccine is returned to the refrigerators and freezers.

5. Other points

- a. Ideally, immunisation clinics should be held monthly. Alternatively, bi-monthly or every 3 months, depending upon the capability of the individual camp.
- b. Measles is a major cause of death and other complications. All children should receive measles vaccine as close to 9 months of age as possible. Whooping cough is an important cause of mortality during outbreaks and attacks the very young. The three doses of DPT should be given as close to the ideal schedule as possible.
- c. Malnutrition rather than a contraindication to measles vaccine is a major indication to give vaccine. The malnourished, younger child is at the greatest risk of mortality and complications from measles.
- d. A fever and/or other illness is not a contraindication to receiving any of the vaccines.
- e. Newborns and new entrants to each camp continue to provide new susceptible children requiring immunisation. All should be identified as soon as possible and directed to a scheduled immunisation clinic.

PART VI. THE STANDARD DRUG LIST

Introduction: Addressed to Doctors and Nurses

People in the Refugee Camps are denied their usual diet and activities, are living in large groups and suffer the sadness and uncertainty of being displaced from their homelands. It is not, therefore, surprising that they should suffer more illness than the "free" host population.

Nevertheless those who attend the sick in the camps must not fall into the trap, which has caught many of us in Europe and America, of feeling obliged to give medication of some sort to every patient who presents.

Many patients in camps will be seen at first by Nursing Auxiliaries who have only elementary diagnostic and therapeutic skills, and it is certain that it requires more experience and skill to decide NOT to give medication than to fire off a pharmacological shotgun.

It is for this reason, among others, that the Guidelines for diagnosis and treatment are set out in the simplest possible way and likewise explains the brevity of the Standard Drug List from which, no doubt, some of your favourites will be absent.

It is hoped that Senior Health Personnel will supervise and teach Auxiliaries the proper use of the Guidelines and of the Drugs in the Standard List, reminding them that every efficacious drug is potentially harmful and should therefore not be given without good reason, and that it is not a sign of ignorance to send some patients away with a few words of explanation and reassurance instead of an injection or a bottle of medicine.

Somali Democratic Republic Refugee Health Unit: Standard Drug List.

1. ANAESTHETICS

General

- * 1.1. Ketamine HC1 inj. 10 mg/ml
- * 1.2. Ketamine HC1 inj. 50 mg/ml

Local:

- * 1.3. Lignocaine HC1 inj. 1%
- * 1.4. Lignocaine HC1 inj. 2% with Adrenaline 1:100.000

2. ANALGESICS/ANTIPYRETICS

- 2.1. Aspirin tablets 300 mg
- 2.2. Paracetamol Elixir paediatric 120mg/5ml
- * 2.3. Baralgine inj.
- * 2.4. Morphine inj. 10mg/ml

3. ANTHELMINTICS

- 3.1. Mebendazole tablets 100 mg

4. ANTIBIOTICS and SULPHONAMIDES

Parenteral:

- 4.1. Benzylpenicillin inj. 1 Mill. I.U.
- 4.2. Procaine Penicillin inj. 3 Mill. I.U.
- 4.3. Triple Penicillin inj. 1.25 Mill. I.U.
(Benetham.Penic.500.000/Proc.Penic.250.000/Benzylpenic.
500.000)
- 4.17. Benzathine Penicillin G inj. 2.4. Mill. I.U.
- + 4.18. Chloramphenicol Sodium succinate inj. lg
- + 4.4. Ampicillin inj. 500 mg

Oral:

- 4.5. Penicillin V tablets 125 mg
- 4.6. Penicillin V tablets 250 mg
- 4.8. Ampicillin capsules 250 mg
- 4.9. Ampicillin suspension 125mg/5ml
- + 4.10. Chloramphenicol capsules 250 mg
- 4.11. Chloramphenicol suspension 125mg/5ml
- 4.12. Tetracycline capsules 250 mg
- 4.14. Co-Trimoxazole tablets 480 mg
- 4.15. Co-Trimoxazole suspension 240mg/5ml
- 4.16. Co-Trimoxazole paediatric tablets 120 mg

5. ANTICONVULSANTS

- * 5.1. Diazepam inj. 5mg/ml
- 5.2. Phenobarbitone tablets 30 mg
- * 5.3. Magnesium sulphate inj.

6. ANTIHISTAMINES

- 6.1. Promethazine tablets 25 mg
- 6.2. Promethazine syrup 5mg/5ml
- 6.3. Promethazine inj.

7. ANTIPROTOZOALS

- 7.1. Chloroquine tablets 150 mg base
- 7.2. Chloroquine syrup 50mg base/5ml
- 7.3. Chloroquine inj. 30 or 40 mg base/ml
- 7.5. Primaquine tablets 15 mg base
- * 7.6. Quinine diHCl inj. 300mg/ml
- 7.4. Metronidazole tablets 250 mg

8. ANTISCHISTOSOMIASIS DRUGS

- 8.1. Metrifonate tablets 100 mg

9. ANTITUBERCULOUS DRUGS

- 9.1. Isoniazid tablets 100 mg
- 9.2. Isoniazid tablets 300 mg
- 9.3. Isoniazid 300mg + Thiacetazone 150mg tablets (TB 1)
- 9.4. Streptomycin inj. lg
- 9.5. Streptomycin inj. 5g
- + 9.6. Ethambutol tablets 400mg

11. **BRONCHODILATORS**
 - * 11.1. Aminophylline inj. 250mg/10ml
 - * 11.2. Ephedrine HCl tablets, 15 or 30 mg
12. **CARDIOVASCULAR DRUGS and DIURETICS**
 - * 12.1 Adrenaline inj. 1mg/ml (1:1000)
 - * 12.2. Atropine sulph. inj. 0.5mg/ml
 - * 12.3. Frusemide inj. 10mg/ml
13. **DISINFECTANTS**
 - 13.1 Cetrimide 40% conc.
14. **GASTROINTESTINAL DRUGS**
 - 14.1 Aluminium hydroxide tablets 500 mg
15. **HAEMATINICS**
 - 15.1 Ferrous sulph. 300mg + Folate 250 mcg tablets
 - 15.2 Ferrous sulph. syrup 125mg/5ml
 - 15.3 Ferrous sulph. powder in sachets of 100g
16. **HORMONES (CORTICOSTEROID)**
 - * 16.1. Hydrocortisone Sod. succ. inj. 100mg/ml
17. **OBSTETRIC DRUGS**
 - * 17.1. Ergometrine inj.
 - 17.2. Ergometrine maleate tablets 0.2mg
18. **OPHTHALMIC PREPARATIONS**
 - * 18.1. Oxybuprocaine eye-drops 0.4%
 - * 18.2. Atropine eye-drops 1%
 - 18.3. Tetracycline eye-ointment 3%
19. **OTIC DRUGS**
 - 19.1. Locorten – Vioform ear drops
20. **PLASMA SUBSTITUTE**
 - * 20.1. Dextran 70, 6% solution in Normal Saline
21. **REHYDRATION**
 - * 21.1. Lactated Ringer (Hartmann's) solution i.v.
 - * 21.2. Darrows solution ½ strength with Dextrose 2.5% i.v. or Lactated Ringer ½ strength in Dextrose 5% i.v.
 - 21.3. Oral rehydration salts (ORS)
22. **TOPICALS**
 - 22.1. Benzyl benzoate application
 - 22.2. Gentian violet powder (for solution)
 - 22.3. Whitfield's (Benzoic acid compound) ointment
 - 22.4. Tetracycline skin ointment 3%
 - 22.5. Vaseline

23. VITAMINS

- 23.1. Vitamin A caps. 200.000 I.U.
- 23.2. Vitamin C tablets 50mg
- 23.3. Vitamin B Complex tablets
- 23.4. Vitamin B6 tablets

24. WATER FOR INJECTION

- 24.1. Water for injection 2ml
- 24.2. Water for injection 5ml
- 24.3. Water for injection 100ml (with preservative)
- 24.4. Water for injection 10ml

25. DIAGNOSTIC AGENTS

- 25.1 Uristix (Combur-Test)

*** EMERGENCY MEDICATION**

+ FOR PHYSICIAN USE ONLY

APPENDIX 1. DEMOCRATIC REPUBLIC OF SOMALIA, THE MINISTRY OF HEALTH: MONTHLY SURVEILLANCE REPORT – REFUGEE CAMPS

Region _____ Camp _____ Month _____ 198

I. Camp Population

- a) Total Population (end of previous month) _____
- b) New arrivals (this month) _____
- c) Births in camp (this month) _____
- d) Deaths in camp (this month) _____
- e) Number of people left camp (this month) _____
- f) Total camp population (end this month) _____

II. Camp Health Personnel

- | | | | |
|-----------------|-------|------------------|-------|
| physicians | _____ | lab. technicians | _____ |
| nurses | _____ | nurse-midwives | _____ |
| nurse-auxiliar. | _____ | TBA | _____ |
| sanitarians | _____ | CHW | _____ |
| asst. pharmac. | _____ | Others | _____ |

III. Mortality

Possible cause of death	Age					
	under 1 month	1 - 11 months	1 - 4 years	5 - 14 years	15+ yrs	TOTAL
Respiratory illness						
Diarrhoea						
Measles						
Malnutrition						
Neonatal death						
Maternal death						
OTHER						
TOTAL						

IV. Morbidity

Number of patients seen at clinic with *one* of the following headings as the *major* presenting condition. If a patient has to return daily for treatment following the first visit he still only counts as *one* for this list.

Symptom(s)	Number	
1. Fever, no cough		
2a. Fever + cough		
2b. Cough, cold, sore throat (no fever)		
3. Fever and chills		
4. Aches and pains		
5. Diarrhoea, no blood		
6. Diarrhoea + blood		
7. Dehydration		
8. Measles		
9. Eye infection		
10. Anaemia		
11. Whooping cough (Pertussis)		
12. Ear infection		
13. Skin diseases		
14. Blood in urine (Bilharzia)		
15. Urinary tract infection		
16. Intestinal parasites		
17. Obst/Gynaecology		
18. Trauma		
19. Venereal disease		
20. Other		
TOTAL		100%

TUBERCULOSIS

No. patients under treatment (end last month) _____

No. new patients (this month) _____

No. patients discharged after 1 full year treat. (this month) _____

TOTAL NUMBER OF PATIENTS under treatment (end this month). _____

APPENDIX 2. SUPPLEMENTARY/INTENSIVE FEEDING DATA

Supplementary Feeding

1. Category	No. enrolled (end last month)	admiss. (this month)	discharges (this month) (over 85%)	Total (end this month)
0-5 years (up to 115cms height) (71-80% standard weight for height)				
pregnant women (last trimester)				
lactating women				
TB patients (As necessary)				
elderly (As necessary)				
medical referrals				
others e.g. children 6-14 years of age				
TOTAL				

Number children
0-5 years attend-
ing daily

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

(Place slash / in boxes on days when all feeding centers
closed)

2. No. of children 0-5 years, who:—

a) Lost weight _____

b) Failed to gain weight _____

Intensive Feeding

3.

Category	No. enrolled (end last month)	admiss. (this month)	discharges (this month)	Total (end this month)
0-5 years (up to 115cms. height) (less than 70% standard weight for height)				
Children with oedema or active disease				
Medical referrals				
Older children (e.g. 6-14 years)				
TOTAL				

Number children
0-5 years
attending daily

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

(Place sash / in boxes on days when all feeding centers closed)

4. No. of children who died whilst in intensive feeding programme
5. What is the percentage of children (excluding those with oedema) losing weight?

Week 1 _____, Week 2 _____, Week 3 _____, Week 4 _____

**WEIGHT FOR HEIGHT PERCENTS OF MEDIAN: UNISEX
NCHS/WHO REFERENCE (KG/CM)**

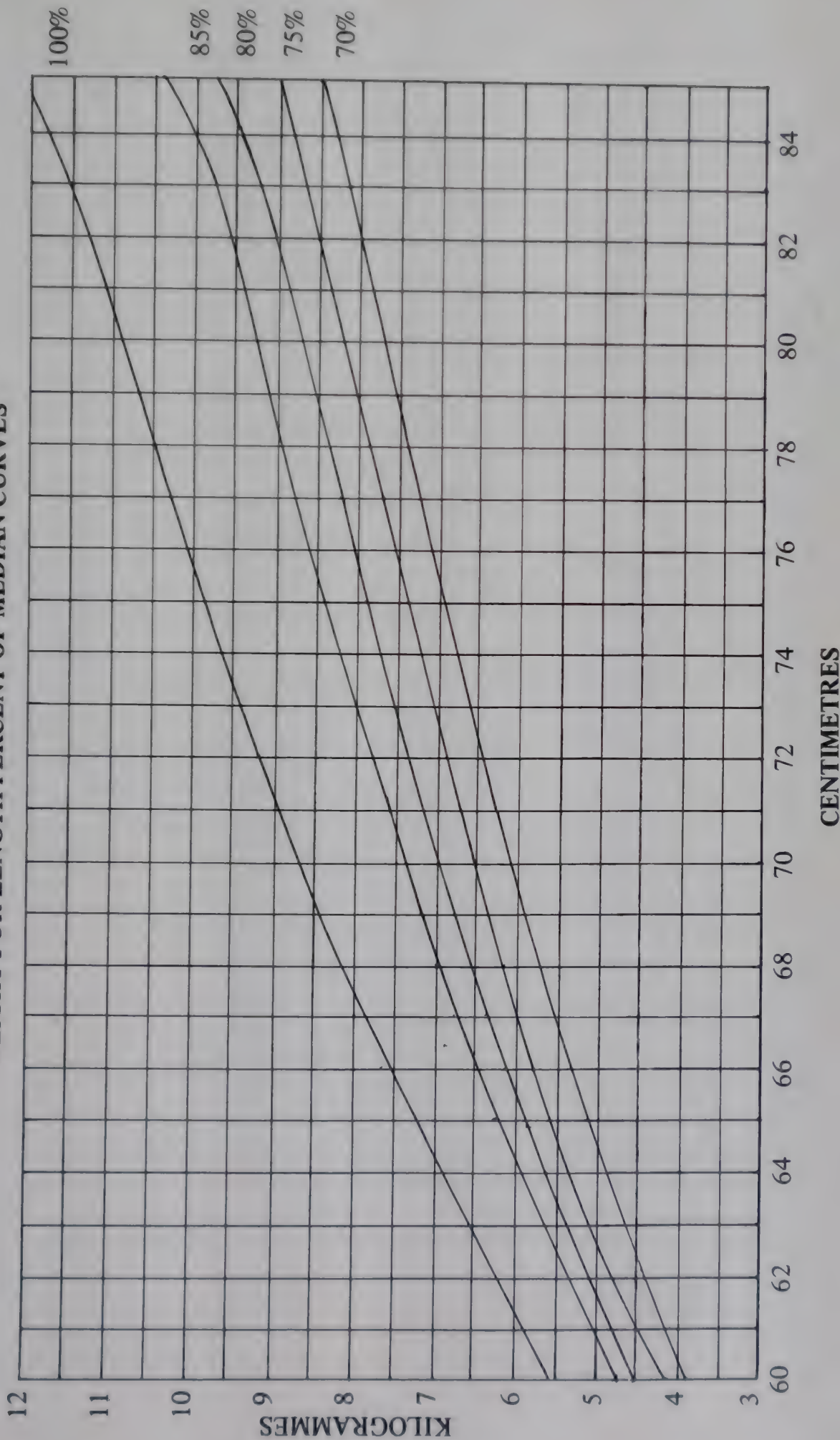
LENGTH	MEDIAN	85% MED	80% MED	75% MED	70% MED
60	5.6	4.8	4.5	4.2	3.9
61	5.9	5.0	4.7	4.4	4.1
62	6.2	5.2	4.9	4.6	4.3
63	6.5	5.5	5.2	4.9	4.5
64	6.7	5.7	5.4	5.0	4.7
65	7.4	6.3	6.0	5.6	5.2
66	7.7	6.6	6.2	5.8	5.4
67	8.0	6.8	6.4	6.0	5.6
68	8.2	7.0	6.6	6.2	5.7
69	8.5	7.2	6.8	6.3	5.9
70	8.7	7.4	7.0	6.5	6.1
71	8.9	7.6	7.1	6.7	6.3
72	9.2	7.8	7.3	6.9	6.4
73	9.4	8.0	7.5	7.0	6.6
74	9.6	8.2	7.7	7.2	6.7
75	9.8	8.4	7.9	7.4	6.9
76	10.0	8.5	8.0	7.5	7.0
77	10.3	8.7	8.2	7.7	7.2
78	10.5	8.9	8.4	7.9	7.3
79	10.7	9.1	8.6	8.0	7.5
80	10.9	9.3	8.7	8.2	7.6
81	11.1	9.4	8.9	8.3	7.8
82	11.3	9.6	9.1	8.5	7.9
83	11.5	9.8	9.2	8.7	8.1
84	11.8	10.0	9.4	8.8	8.2
85	12.0	10.2	9.6	9.0	8.4
86	12.2	10.4	9.8	9.1	8.5
87	12.4	10.6	9.9	9.3	8.7
88	12.6	10.7	10.1	9.5	8.8
89	12.9	10.9	10.3	9.7	9.0
90	13.1	11.1	10.5	9.8	9.2
91	13.3	11.3	10.7	10.0	9.3
92	13.6	11.5	10.8	10.2	9.5

**WEIGHT FOR HEIGHT PERCENTS OF MEDIAN: UNISEX
NCHS/WHO REFERENCE (KG/CM)**

LENGTH	MEDIAN	85% MED	80% MED	75% MED	70% MED
93	13.8	11.7	11.0	10.3	9.7
94	14.0	11.9	11.2	10.5	9.8
95	14.3	12.1	11.6	10.7	10.0
96	14.5	12.4	11.6	10.9	10.2
97	14.8	12.6	11.8	11.1	10.3
98	15.0	12.8	12.0	11.3	10.5
99	15.3	13.0	12.2	11.5	10.7
100	15.6	13.2	12.4	11.7	10.9
101	15.8	13.5	12.7	11.9	11.1
102	16.1	13.7	12.9	12.1	11.3
103	16.4	13.9	13.1	12.3	11.5
104	16.7	14.2	13.3	12.5	11.7
105	16.9	14.4	13.6	12.7	11.9
106	17.2	14.6	13.8	12.9	12.1
107	17.5	14.9	14.0	13.1	12.3
108	17.8	15.2	14.3	13.4	12.5
109	18.1	15.4	14.5	13.6	12.7
110	18.4	15.7	14.8	13.8	12.9
111	18.8	16.0	15.0	14.1	13.1
112	19.1	16.2	15.3	14.3	13.4
113	19.4	16.5	15.5	14.6	13.6
114	19.8	16.8	15.8	14.8	13.8
115	20.1	17.1	16.1	15.1	14.1
116	20.5	17.4	16.4	15.4	14.3
117	20.8	17.7	16.7	15.6	14.6
118	21.2	18.0	17.0	15.9	14.9
119	21.6	18.4	17.3	16.2	15.1
120	22.0	18.7	17.6	16.5	15.4

WEIGHT FOR LENGTH (HEIGHT) PERCENT OF MEDIAN CURVES: SEXES COMBINED, 60-120 CMS

WEIGHT FOR LENGTH PERCENT OF MEDIAN CURVES



WEIGHT FOR HEIGHT PERCENT OF MEDIAN CURVES

